

# MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

DO NOT WRITE  
ON THIS STUB

AMENDED

Registration District No. 149

Primary Registration District No. 1002 Registrar's No. 6592

STATE FILE NUMBER 62-046930

FILED JAN 14 1963

1. PLACE OF DEATH

a. COUNTY

JACKSON

b. CITY (If outside corporate limits, give TOWNSHIP only)

KANSAS CITY

Length of stay in 1b

27 yrs

c. CITY

OR TOWN

KANSAS CITY

c. FULL NAME OF (If NOT in hospital, give location)  
HOSPITAL OR INSTITUTION

1524 Troost Apt 114

Inside Limits

Yes ☒ No ☐

d. STREET ADDRESS

1524 Troost

(If outside, give location)

Reside on Farm

Yes ☐ No ☐

3. NAME OF DECEASED  
(Type or print)

First

EARL

Middle

EUGENE

Last

HARRIS

4. DATE OF DEATH

Month

Day

Year

12-25-62

5. SEX

Male

6. COLOR OR RACE

Negro

7. Married ☐ Never Married ☐

Widowed ☒ Divorced ☐

8. DATE OF BIRTH

8-11-1903

9. AGE (last birthday)

59 yrs

IF UNDER 1 YEAR

Months

Days

Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

Laborer

10b. KIND OF BUSINESS OR INDUSTRY

Construction

11. BIRTHPLACE (City and state or country)

Dallas, Texas

12. CITIZEN OF WHAT COUNTRY

USA

13a. FATHER'S NAME

Unknown

13b. MOTHER'S MAIDEN NAME

Unknown

14. NAME OF HUSBAND OR WIFE

Lula Harris

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)  
NO

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

Eddie Harris 1524 Troost Apt 114 Son

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Myocardial Insufficiency

INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Chronic Myocarditis

DUE TO (c)

Arteriosclerosis

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?  
YES ☐ NO ☒

20a. ACCIDENT ☐ SUICIDE ☐ HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m. Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from \_\_\_\_\_, to \_\_\_\_\_ and last saw her alive on \_\_\_\_\_.  
Death occurred at \_\_\_\_\_ m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

22b. ADDRESS

22c. DATE SIGNED

L. J. Tillman M.D. Deputy Coroner 1615 Lydia Ave.

12/26/62

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE

12-30-62

23c. NAME OF CEMETERY OR CREMATORY

23d. LOCATION (City, town, or county)

(State)

24. FUNERAL DIRECTOR

ADDRESS

25. DATE RECD. BY LOCAL REG.

26. REGISTRAR'S SIGNATURE

Watkins Bros. Funeral Home 18th & Benton

12-26-62

Ruth Long

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

DATE AMENDED

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

**STATEMENT BY LICENSED EMBALMER**

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,  
or by \_\_\_\_\_, Student Embalmer No. \_\_\_\_\_  
working under my personal supervision.

Student \_\_\_\_\_  
Signature of Student Embalmer

Signed

*Bruce R. Watkins*

Licensed Embalmer No. 4500

P. O. Address

18th & Benton

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.